Applicant's SSN
(from Page 1, Section I) | | | | - | | | - | | | | |

SECTION V: CUSTODIAL PARENT INFORMATION

Dependent(s) listed that do not live with you may only be covered if the employee (or spouse) has a court or administrative order requiring insurance coverage for health care expenses of the child. Coverage provided due to a court or administrative order may not be terminated without proper documentation.

Dependent's Social Security Number

			-			-				
			-			-				

Custodial Parent Name

All Dependents? ☐ < Yes

Custodial Parent Address

Country / Mail Code
(If not U.S.A.)

SECTION VI: FLEXIBLE SPENDING ACCOUNT

If you are eligible and would like to participate in a Flexible Spending Account, you must complete a separate enrollment form.

Is the appropriate Flexible Spending Enrollment Form attached? ☐ Yes ☐ No

Contact your Insurance Coordinator for specific details regarding the FSA enrollment process.

SECTION VII: AUTHORIZATION AND CERTIFICATION

* My signature below certifies that I understand the statements on this form are true and complete to the best of my knowledge.
* I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan contract.
* I agree to abide by the terms and the conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or void the contract.
* I understand that the selections indicated on this enrollment form may not be changed or canceled during the year of coverage with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
* I elect to participate in the Premium Conversion Program unless I sign the cancellation form. [For more information on Premium Conversion, see the Health Insurance Handbook.]
* My signature below certifies that I have read the Health Insurance Handbook and agree to be bound by its terms and conditions. All information listed on this application was completed with knowledge of the Handbook's terms and conditions, and I accept full responsibility for any deficiency concerning my application due to a failure to conform to the Handbook's terms and conditions.
* I understand that participation in a Flexible Spending Account requires completion of a separate enrollment form specific to that plan.

Employee Signature — Date

Spouse Signature — Date
(***Only REQUIRED if applying for a cross-reference plan)***

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the state-sponsored health insurance plan. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Insurance Coordinator Signature — Date

Signature of Spouse's Insurance Coordinator — Date
(***Only REQUIRED if applying for a cross-reference plan)***